MedHealth **R**eview, **I**nc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 8/6/12

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of inject spine L/S (CD), fluoroguide for spine inject, epidurography, mod cs by same phys 5 + years, mod cs by same phys add-on, surgical trays, surgical supplies, therapeutic exercises (12 units), neuromuscular re-education (12 units) and physical medicine (12 units).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of inject spine L/S (CD), fluoroguide for spine inject, epidurography, mod cs by same phys 5 + years, mod cs by same phys add-on, surgical trays, surgical supplies, therapeutic exercises (12 units), neuromuscular re-education (12 units) and physical medicine (12 units).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Sedgwick CMS Management and MD.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: follow up notes by Pain Institute 9/1/11 to 5/22/12, 9/8/11 to 4/18/12 operative reports, and lumbar CT report 12/15/11.

Sedgwick CMS: 5/24/12 preauth request, 5/22/12 script, undated progress eval, 5/26/12 peer review report, 6/11/12 peer review report, 5/31/12 denial letter, 5/22/12 PT script, Disability Eval Center HICFA 1500 6/5/12, 5/23/12 report by, DO, 6/24/12 peer review report, and 6/26/12 denial letter.
A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant has an injury date of xx/xx/xx. There is no mechanism of injury provided. She does have an SCS which the notes indicate she is using it 1% of the time. She did have an ESI 2/1/2012 with 80% relief. However, on 2/16/2012 there is a report that the pain returned. On 4/18/2012 another ESI provided some relief that was short lived. Her previous physical therapy notes are not provided. A job description is not provided. Her current functional level is not provided. Another ESI has been requested and denied by the carrier.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This patient does not meet the ODG criteria for a repeat ESI. ESI are appropriate for the short term treatment of radicular pain used in conjunction with active rehab efforts. The radiculopathy must be documented with objective findings on examination. There are no findings on MRI, there is no change in reflexes, and the complaints are subjective. In the therapeutic phase, when blocks are used there should be pain relief of at least 50 to 70% that lasts 6 to 8 weeks. This was not the case here. She has an SCS that is being used minimally. A physical therapy program is not indicated. It is not found to be more beneficial than a home program at this stage of care. The need for supervision from a physical therapist is not indicated. Therefore, according to the ODG criteria, the services that have been requested are found to be not medically necessary at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**